reviews

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A Study of Story Telling, Humour and Learning in Medicine: H M Queen Mother Fellowship, Eighth Lecture

Kenneth Calman

Stationery Office, £17.50, pp 175
ISBN 0 11 702516 X

Rating: ★★★

In an apocryphal cartoon, a general practitioner opens his door to call for the next patient and reveals the slogan on his T shirt: "Campaign for real ailments." You smiled, perhaps, out of empathy with the doctor in the picture and also at the incongruity of a doctor boldly displaying such a sentiment when seeing patients. The joke throws into focus the difficult task of maintaining one's professional demeanour during trivial or challenging consultations. We've all been there, ha ha.

Having dissected this story, we have now removed its spontaneity and appeal—and thereby killed the humour. Never ask someone to explain the punch line of a joke you didn't "get." That being the case, the deconstruction of humour is surely a non-starter as a theme for a book. But Calman manages to take us successfully through the physiology, psychology, etymology, sociology, and even philosophy of laughter before asking whether there is any evidence for the claim that laughter is "the best medicine."

Humour, he suggests, can have profound therapeutic and educational benefits. We feel better—we are better—when we've had a good laugh. Those who work with, or are on the receiving end of, the "unmentionable" dimensions of medical practice—death, disability, disfigurement, and loss—use humour to distance themselves from the seriousness of these issues. Here's one I was told by a patient with claudication:

"Mr Jones," said the surgeon, "I have some bad news and some good news. The bad news is that we had to amputate both of your legs. The good news is that the man in the bed opposite you wishes to buy your slippers."

We learn from jokes. Calman quotes an *Economist* article that begins "To understand a country, you can study its economic data or demographic statistics. Or you can collect its jokes." The same goes for medical subcultures. How many psychotherapists does it take to change a light bulb? Only one, but the light bulb has got to want to change.

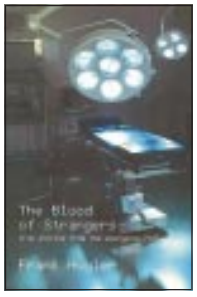
Other chapters cover the traditional case history and its use in learning and teaching, and the clinical applications of poetry, dance, mime, and other narratives. The more we look for stories in clinical practice, Calman suggests, the more we find them: even the well rehearsed rituals of the surgical expert engaged in a difficult technical procedure are a form of "storytelling."

This book was written by a distinguished academic whose own clinical background is in oncology and palliative care, whose passionate interest is literature, and who built lasting bridges between medicine and the arts while holding the post of chief medical officer for England. It was commissioned as a 100th birthday present for the Queen Mother. Given this context, it would be inappropriate to criticise Calman for not offering an epistemologically coherent and "evidence based" framework for his assortment of quotes, impressions, stories, and caricatures.

Trisha Greenhalgh *general practitioner, London*

The Blood of Strangers: True Stories from the Emergency Room

Frank Huyler



Fourth Estate, £10, pp 188
ISBN 1 84115 445 8

Rating: ★★★

Frank Huyler is an emergency room physician in "it's all a bit quirky" Alberquerque, New Mexico. He describes the characters of a vast spectrum of patients and doctors: a surgeon who unexpectedly commits suicide; a neurosurgeon who speaks in tongues; a man who was chased across the desert by a heat seeking missile; and a strong believer in God who refuses life saving treatment.

All 28 short stories in this collection are based on lightly disguised real situations from Huyler's medical career. The first story does not shy away from being graphic. It details an account of saving an armed robber's life by "scooping out handfuls of clotted blood" from his bullet wounded chest.

Apart from the first story, the book is in chronological order, from Huyler's days at medical school through to his life as a hospital doctor. As a medical student, I find it easy to relate to his tales of medical training. During the dissection of his cadaver, he finds the cause of death—a cancer ridden lung. He holds it in his hands and begins to picture what kind of life the corpse led, even though it has been reduced to pieces.

Cases of emergencies are told with extreme pace. One involves Huyler saving a young man's life by inserting a needle into his chest, seconds after realising the patient had a tension pneumothorax.

Another case describes the mental and physical drain of monitoring a critically ill patient who has spent more than a month in intensive care. "I have come to dread him."

Huyler finds that, after a while, he comes to rely on first sight when he approaches a case. He thinks "sick" or "not sick." When "not sick," patients get discharged immediately. But he admits that sometimes he gets it wrong. A patient goes into anaphylactic shock, and Huyler realises his mistake—the patient is allergic to the drugs he was given. The panic that follows in the emergency room is so well portrayed that I felt my heart rate increase tenfold.

The Blood of Strangers is a quick but satisfying read. Although tales from the emergency room have become rather clichéd since television dramas such as *ER*, Huyler's poetic ability creates something original.

Giles Kent *intercalating medical student, University of Westminster*

Items reviewed are rated on a 4 star scale (4=excellent)

Severed Trust: Why American Medicine Hasn't Been Fixed

George D Lundberg with James Stacey

Basic Books, £18.99, pp 336
ISBN 0 465 04291 0

Rating: ★★★★

In this magnificent insider's account, George Lundberg explains how American medicine got into its current mess and offers suggestions for its resuscitation. Lundberg has spent 50 years in medicine, from pre-med student mopping operating rooms in a country hospital to editor of the *Journal of the American Medical Association* and now editor in chief of Medscape, a leading internet site.

Trained as a pathologist when medicine was changing from general practice to specialisation, he has worked in large and small hospitals across the United States, as a doctor in the US army, as head of pathology at a major teaching hospital, and as a professor at leading medical schools. For 17 years he edited *JAMA*, which he raised from trade journal to member of the international big five.

"Part of a medical editor's job involves getting into hot water," he writes. He describes how, under his editorship, *JAMA* began theme issues on tobacco, violence, nuclear warfare risks, and alternative medicine. It published papers on deaths and injuries from medical errors, violence as a public health issue, gun control, use of illegal drugs, therapeutic touch, addictions, and the physician's role in easing the death of terminally ill patients. These peer-reviewed papers produced headlines, and anger and praise from doctors and the public. He was fired for publishing a paper that showed American students didn't think oral sex was "real sex," during President Clinton's impeachment.

Lundberg explains how American medicine declined from profession to business, why many doctors have lost joy in their work, and why the public views them as money-grubbing white coats who call sick people "cases." Beginning in the 1950s, medicine became more sophisticated and expensive. For employers, health insurance was tax deductible, and patients paid only a small amount, so who cared how much it cost?

US legislators expanded the National Institutes of Health, set up the Veterans Administration hospital system, provided funds for hospital construction, and enacted Medicare for the elderly and Medicaid for the poor. Lundberg laments that doctors ended their historic obligation to provide charity care because someone would probably pay for it. New medical schools opened, new doctors graduated and—surprise—they entered specialties, especially those caring for the elderly. Costs soared. Autopsies, a key to quality control, fell close to zero. Procedures such as bone marrow transplants for advanced breast cancer were demanded without clinical trials proving whether or not they worked.

AP PHOTO/BEBETO MATHEWS

Lundberg: offering an unusual solution

To control costs, Lundberg explains, employers embraced managed care organisations that "cherry picked" companies with young, healthy employees and raised rates for small firms where one employee had an expensive illness. They did not pay for clinical trials. Today, 44 million Americans have no health insurance. All the health insurance industry does "is collect money, keep as much of it as possible, and dole out as little as possible," Lundberg writes.

How can this broken system be fixed? Lundberg has an unusual suggestion not proposed, as far as I know, by any other US health expert: the Singapore Solution. Through a payroll tax, everyone would receive free preventive care proven by scientific trials: childhood immunisations, cervical smears, mammograms. Everyone would be covered for traumatic situations requiring hospital care. Other care would be optional and paid for by the patient.

Lundberg calls for national standards and licensing (which is now state by state), more public information about doctors' malpractice and disciplinary histories, and an independent body (not a doctors' trade association) to provide leadership. He suggests the Institute of Medicine of the National Academy of Sciences. He says all this will take time. Wish him luck.

Janice Hopkins Tanne *medical journalist, New York*

Condoms

Ed Adrian Mindel

BMJ Books, £19.95, pp 240
ISBN 0 7279 1267 4

Rating: ★★★

In 1736 the French venereologist Jean Astruc condemned English libertines' use of animal membrane condoms. "Surely it is far better," he said, "to partake the pleasures of venery with permission and safety, than to make use of so filthy and nasty an invention." While such prejudice may remain widespread, I hope that health professionals would now disagree.

Condoms are a reliable contraception that can be used independently of medical input or advice and are an effective barrier against sexually transmitted infections. Up to 10 billion a year are used worldwide. Despite this, the global number of sexually transmitted infections is estimated to be in excess of 150 million, in addition to about 50 million abortions and 30 million unintended pregnancies.

This paperback seeks to promote condom use by providing an accessible and comprehensive literature review. The 19 contributors are mostly international experts who have published widely. The 14 chapters are independent, but repetition is minimal. The editor has achieved a consistent and readable style, incorporating both summaries of evidence and visions of future prospects and challenges.

One chapter provides a fascinating historical overview, and others deal with the effectiveness of condoms against conception and infection and research on condom use, including the factors influencing their use, availability, and accessibility. More specialised topics include use of condoms in commercial and anal sex, spermicides, and female and non-latex condoms.

There is no clear description of the process of literature search and critical appraisal underpinning the evidence presented, which will disappoint those seeking more systematic reviews. However, such an approach might have made the book less accessible to non-experts, and for some topics this kind of search would have been impractical.

Condoms has the answers to many questions posed and pondered by patients and professionals, including some fascinating ones that you have probably never thought of.

Mark Gabbay *senior lecturer in general practice, University of Liverpool*

The execution of Timothy McVeigh: must see TV?

On 19 April 1995, 7000 lbs of explosives detonated alongside the Alfred P Murrah Federal Office Building in Oklahoma City. Without warning the bomb punched a gaping hole through offices and a daycare centre, killing adults and children; 163 died inside the building, four more died outside, and a final victim was killed entering the scene to help the wounded.

Timothy McVeigh, despite his earplugs, heard the deafening roar of the blast and felt the thump of air lift him an inch off the ground. Falling bricks hit him in the leg and a snapped live wire threatened his life. McVeigh, who lit the fuse creating the bloody, horrifying, hideous scene behind him, did not look back. He first saw the devastation via CNN and was momentarily irritated at the sight of the building still standing.

McVeigh is scheduled to die via lethal injection on Monday 11 June, barring further delay. The large number of survivors and those with deceased relatives who wish to see McVeigh die led attorney general John Ashcroft to rule that 250 selected people be allowed to watch the execution via closed circuit television. McVeigh has suggested it would be a good idea to televise his death live for all to see and the company Entertainment Network Incorporated has filed a suit for the webcast rights.

You may be tempted to ask: what next? A lottery for the right to push the syringe plunger? But the argument for televising McVeigh's execution is not frivolous. Execution is committed by the state in the name of the people. Why should it be mysterious and hidden from view? Much of the argument against televising state executions comes from a low opinion of the public. Some, we are told, will view McVeigh as a martyr; others will demonstrate extreme bloodthirsty satisfaction; still others will be traumatised. Part of this is true, but we are being naive if we think that not broadcasting McVeigh's execution will deter those oddballs viewing him as a martyr, and honesty demands we accept some part if execution is the opportunity for revenge. Executions *are* brutal, they involve the deliberate killing of a human being, and if we cannot stomach seeing this then perhaps we should not do it at all.

So far the only debate there has been about the McVeigh execution has been about whether or not it should be broadcast. This issue is the only show in town. There has been no wider or more serious debate out the death penalty itself. In a nation so certain that McVeigh should die, opponents of the death penalty are easily overwhelmed. McVeigh has expressed his own eagerness to be executed and few wish to discourage him. Questions such as "Who is Timothy McVeigh?" and "Why did he do it?" have been muffled and the issue of whether he can be "reformed" or "saved" completely ignored.

This situation is perhaps understandable but deeply regrettable. McVeigh is not some "psychokiller" beyond the bounds of civilisation but is part and product of our society and we should be concerned about his life. As revealed in the book *American Terrorist* (Regan Books, 2001), McVeigh was a highly decorated soldier who fought in the Gulf war. He ultimately viewed the Gulf as an unfair fight, a hi-tech turkey shoot rather than a war, and he abandoned a promising career in the army.

AP PHOTO/DAVID LONGSTREATH

McVeigh: should his death be broadcast live?

A smart kid, still in his early 20s, McVeigh could not find appropriate work. He drifted around gun shows, sucking down their outdated, paranoid, conspiratorial, and simply bizarre brand of politics. Events at Waco confirmed his nascent view of the federal government as an oppressive apparatus systematically removing liberties from ordinary Americans.

His disgust at a bullying government took an uneasy turn towards the need to hit back with something big: a death count high enough that the government would notice, stop, and listen. He had learnt from the American military that a massive death toll could strike fear into the heart of any despot or tyrant and he had learnt to dismiss civilian casualties as unfortunate but necessary "collateral damage." McVeigh walled off his emotions and drove to the federal building not, in his mind, as a sadistic killer but as a soldier entering battle. Later psychiatric assessment of McVeigh portrayed him as an essentially good person who did a truly terrible thing.

Many of the victims' family members have said that they wish McVeigh could show remorse, accepting that his actions were depraved. With psychiatric help there is the hope that McVeigh might eventually pull down his emotional wall and conclude his opinions and actions were fundamentally immoral. He may offer insight as to how a young man could drift so dangerously far from reality. This will not happen while he is on death row and clearly not once he is killed. McVeigh's atrocity was born out of our world and one day he could be a reformed character, but it seems we are going to kill him anyway. Perhaps that should be televised for posterity and for us.

Stuart W G Derbyshire *assistant professor, University of Pittsburgh Medical Center, USA*

WEBSITE OF THE WEEK

Poverty: making a difference Sometimes we get so overwhelmed by the extent of global poverty that we don't see the point in doing anything about it at all. However, a paper in this week's *BMJ* (p 1209) shows how relatively simple interventions, such as improving housing conditions, can have a dramatic effect. Do not be discouraged. There is always something that can be done that does not involve rioting in the streets.

There are many respected international charities committed to tackling poverty at a grassroots level. Action Aid (www.actionaid.org) and Oxfam (www.oxfam.org) are two such examples. Most promote regular giving as opposed to one-off donations.

The International Health Exchange (www.ihe.org.uk) believes that everyone regardless of background or circumstance has the right to good health care. IHE regularly advertises vacant positions for health professionals in developing countries and also supports the work of international aid agencies working for improvements in health care across the world such as Action Health (www.skillshare.org), Merlin (Medical Emergency Relief International; www.merlin.org.uk), and Médecins Sans Frontières (www.msf.org). If you want to organise working abroad yourself, www.medicstravel.com gives some useful advice.

The success of the Jubilee 2000 (www.jubilee2000.org) campaign in highlighting the problem of third world debt and changing government policy proved that getting involved could make a difference. The campaign continues with many other organisations such as drop the debt (www.dropthedebt.org) and Medact (www.medact.org) planning to form a peaceful human chain at the G8 summit in Genoa in July this year.

Rhona MacDonald
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PERSONAL VIEW

The NHS revisited

I was one of those doctors who emigrated from Great Britain in the late 1960s, now over 30 years ago. At that time the NHS seemed to have reached its lowest point since its inception in 1948. I have been in practice in Africa for over 25 years.

Since emigrating I have hardly ever returned to England, so recently I decided to do some general practice locums and get the feel and rhythm of the NHS again. I worked in five London general practices and one in Essex. The man from the locum agency, who acted rather like a controller from a John Le Carré spy novel, would ring me up and send me off.

My first locum was for a singlehanded general practitioner in south London. Over half the practice patients were either on housing or income support. I had forgotten about the sheer drudgery of inner city life. The lonely aged person's ceremonial visit to the doctor. The smell of urine in the tenement lift. It all made me feel profoundly depressed.

What surprised me most was that the practice itself was such a shambles. Data retrieval was a nightmare. There were an estimated 3000 patients but only four filing cabinets and there was an overflow of files into shoe boxes along the window sills and on to the floor. The weighing machine was broken and so was the latch on the consulting room door, which drifted slowly open when the wind blew.

My second patient had wax in his ears so I went to the basin to get some warm water to syringe them only to find that there was one tap. There was no hot running water. I had to boil up the water in an old kettle with a frayed wire.

I had come from under my tree in Africa back to the capital of my old country to find a practice whose only concession to the twentieth century was a telephone and a typewriter. It had technically and intellectually not yet reached the same level of development as the rural Devon practice I had left almost 30 years ago.

My controller at the locum agency, who was obviously a man with a well developed sense of the paradoxes of life, then sent me to a practice in west London. It was a state of the art, architect designed building. Computers hummed on the consulting room desks and filing cabinets moved on oiled rollers. There was complete orderliness with the appointments in a neat column on the screen and a large waiting room with a couple of silent patients sitting next to a designer plant. I had been transferred from Jurassic Park to a Star Ship within the same city.

During my stay I continually found myself in a time warp from the 1960s. My glasses were heavy with the tint of rose. I was saddened by the lack of confidence of the patients. I had remembered the confident British mothers and nannies secure in their positions as wives and mothers. The ones who had handed out the tea in the Blitz.

The modern media of press and television seemed to have frightened the elderly patients into a perpetual fear of cancer, heart attacks, and stroke and the young mothers into a state of apprehension of all sorts of strange and exotic children's diseases.

> Practice seemed to have become part time, bitty, sessional, and agency driven

There had also been a lot written about the single parent family, but I had not anticipated the reality of the numbers of single mothers and their orbiting children that packed the waiting rooms.

I was also surprised at the divorce rate in the elderly. In one week I met two patients in their 60s who had recently got divorced and one at 70 years old. I wondered whether they were they catching it from their children.

Then there was the phenomenon of young men and women smelling of alcohol in the morning surgery. In the 1960s the stereotype of an alcoholic was of a tramp in the park. The family alcoholic was still hidden in the Victorian closet. Now looking at me were these young faces, deep with some kind of Orwellian despair and almost frighteningly uncaring of their fate.

Sadly, I also sensed that many doctors had been worn down by the obstacles placed between themselves and the patients. They were floating downstream and focused on retirement or ways of getting out. Practice seemed to have become part time, bitty, sessional, and agency driven.

Perhaps one of the reasons was the time that I found wasted with interminably drawn out complaints from patients about waiting times for hospital appointments, delayed or lost reports, and general administrative problems. I felt as if I was trying to swim through porridge. This is probably such an accustomed feeling for those who have been working in the system for a long time that they have come to accept it.

Chris Ellis *general practitioner, Pietermaritzburg, KwaZulu\Natal, South Africa*

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

SOUNDINGS

Death in the parlour

One of the unavoidable features of rural general practice is the proximity of suffering. At times it seems as though a miasma of pain and premature death hangs in little pockets around the valley, affecting patients, neighbours, and friends. As one stays longer in practice, the picturesque villages become shrouded with recollections not apparent to the casual visitor.

As a trainee I was told that this was a privilege, a claim I viewed then, and now, with some ambivalence. There is certainly an edge to observing suffering on the mattress in the front room that, personally, I did not experience on the hospital ward. I remember a friend, an experienced surgical trainee, vomiting at the sight of blood at the scene of a car crash. The juxtaposition of blood with tar and grit forms an altogether different texture from that of blood with vinyl and steel. Equally, the texture of pain seems different when projected against the vignette of a sideboard pregnant with memorabilia.

Inevitably, in unguarded moments, you start to wonder how you will react when you are no longer an observer, but are a more active participant in pain. It is clear that there is an art to suffering with dignity. Those who manage it seem to achieve a certain detachment—a sense of irony which, while it does not necessarily soften the experience, at least seems to makes it endurable. But you also see those who suffer sharply, determined to wound as well as be wounded.

Personally, I think I'll opt for the grouchy, difficult old curmudgeon performance—a role my family tells me I have been perfecting over the years. I'll grumble about youth, explicit sex on television, and the government (so no change there, then). But I hope I won't complain about my lot—that way lies real pain.

So what about that old chestnut about an omnipotent good god and the existence of suffering in the world? ("Don't ask me that question," says God in the BBC Radio 4 comedy *Old Harry's Game*. "It really pisses me off.") Well, the answer, as usual, was discovered by the eminent metaphysical philosopher Woody Allen. He was asked in an interview whether he felt the presence of so much suffering in the world meant that, if God exists, He must be evil. Not actually evil, Allen mused. The worst that can be said about Him is that He's an underachiever.

Kevin Barraclough *general practitioner, Painswick, Gloucestershire*